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	155580	A. BUILDING 00 B. WING	08/23/2011

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F0000	This visit was for the Recertification and State Licensure Survey. This visit was done in conjunction with the Investigation of Complaint IN00095023. Survey Dates: August 15, 16, 17, 18, 19, 22, and 23, 2011 Facility Number: 008505 Provider Number: 155580 AIM Number: 200064830 Survey Team: Heather Tuttle, R.N. T.C. Lara Richards, R.N. Janet Adams, R.N. Kathleen Vargas, R.N. Census Bed Type: 125 SNF/NF 125 Total Census Payor Type: 17 Medicare 94 Medicaid 14 Other 125 Total Stage 2 Sample: 38 These deficiencies reflect state	F0000	Allegation of Credible ComplianceThis plan of Correction is prepared and executed because it is required by the provision of State and Federal law and not because Timberview Health Care Center agrees with the allegations and citations listed on pages 1-65 of this statement of deficiency. Timberview Health Care Center maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care. This plan of correction shall also operate as the facility's written credible allegation of compliance, please accept September 22, 2011, as the date of compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	findings cited in accordance with 410 IAC 16.2. Quality review 8/30/11 by Suzanne Williams, RN			

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F0156 SS=A	The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;			

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	A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.			

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	The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. Based on record review and interviews the facility failed to ensure liability letters on the correct CMS forms were given to residents who were being discharged from the facility with Medicare days remaining for 2 of 3 residents reviewed for Liability Notice of the 3 residents who met the criteria for Liability Notice. (Residents #56 and #178) Findings include: The records for Residents #56 and #178 were reviewed on 8/22/11 at 2:12 p.m. Resident #178 was admitted to facility on 8/11/09 with her current re-admission to the facility on 4/1/11. She was admitted to the facility on 4/1/11 with Medicare coverage from an acute care setting. The resident was discharged from the facility with Medicare days remaining on 4/14/11.	F0156	1. Immediate action for the residents #56 and #178 is not applicable as the residents are no longer at the facility.2. There were no outstanding notices upon follow up of this finding.3. The system in place is MDS Coordinator completes the forms. Social Services notifies the resident/responsible party. Business Office to mail letter as required. MDS, Social Services, and Business office received inservice training related to the process for Medicare liability letters on the correct CMS forms.4. The Business Office Manager will maintain a tracking log to indicate compliance with this requirement. The administrator/designee will review each letter for one month; then weekly review thereafter. Results will be reviewed in quality assurance committee meetings.	09/22/2011

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	Resident #56 was admitted to the facility on 1/7/11 with her payor source as Medicare. The resident was discharged from the facility on 4/26/11 with Medicare days remaining. Interview with the Administrator on 8/22/11 at 2:12 p.m. indicated there were no "cut" letters provided to any of the above mentioned residents at the time of discharge to inform them of their days remaining of Medicare coverage. She indicated they did not provide the CMS form letter to these residents at the time of discharge. 3.1-4(l)(1)			
F0247 SS=B	A resident has the right to receive notice before the resident's room or roommate in the facility is changed. Based on record review and interview, the facility failed to ensure notice of roommate change was provided prior to the change for 3 of 3 residents who met the criteria for room transfers. (Residents #38, #54 and #K)) Findings include: 1. Interview with Resident #K on 8/15/11 at 10:57 a.m., indicated that he had a roommate change in the	F0247	1. Immediate action was taken for Residents #K, #38, and number 54 by informing them at time of survey of roommate situation. No concerns noted by any resident. 2. Other residents were identified by reviewing all resident room changes in the last 30 days and no additiontional concerns noted. 3. The system in place is that Social services will confirm with admissions coordinator or designee in morning meeting five times per week when there are new admits	09/22/2011

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	past nine months. He indicated he was not informed that he was going to have a new roommate. A list was provided by the Social Services Assistant on 8/18/11 at 9:30 a.m. The list indicated the dates when Resident #K received a new roommate. The list indicated that the resident had roommate changes on 3/3/11, 5/25/11, 6/29/11 and 7/18/11. The social service progress notes and the nursing progress notes dated March 2011, May 2011, June 2011 and July 2011, were reviewed. There was no documentation the resident was informed that he was to receive a new roommate. 2. Interview with Resident #38 on 8/16/11 at 9:33 a.m., indicated she had roommate changes in the past nine months. She indicated she was not informed each time that she was to have a new roommate. A list was provided by the Social Services Assistant on 8/18/11 at 9:30 a.m. The list indicated the dates when Resident #38 received a new roommate. The list indicated that the resident had roommate changes on 2/17/11 and 5/5/11.		and which rooms they will be assigned to. When there is a potential roomate, social services will notify residents that they will get a new roommate and chart in progress notes that they were notified as to the fact. 4. The systemic changes will be monitored by the Administrator/designee by a review of charts, for three months, whereby current residents are receiving a new roommate and quarterly thereafter. Audit results will be shared in monthly QA until 100% compliance is evidenced via resident interviews.	

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	The record for Resident #38 was reviewed on 8/18/11 at 10:10 a.m. The nursing progress notes and the social service progress notes dated February 2011 and May 2011, were reviewed. There was no documentation that the resident was informed that she was to have a new roommate. 3. A list was provided by the Social Services Assistant on 8/18/11 at 9:30 a.m. The list indicated the date when Resident #54 received a new roommate. The list indicated that the resident had a roommate change on 4/20/11. The record for Resident #54 was reviewed on 8/18/11 at 10:16 a.m. Review of the nursing progress notes and the social service progress notes dated April 2011, indicated there was no documentation the resident was informed that she was to receive a new roommate. Interview with the Social Service Director on 8/18/11 at 11:13 a.m. indicated there was no documentation in the residents records that the residents were informed they were to have a new roommate. 3.1-3(v)(2)			

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F0250 SS=D	The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on observation, record review and interview, the facility failed to ensure medically-related social services were provided for a resident related to not arranging for teeth extraction after a dental referral was made. This affected 1 of 3 residents reviewed for dental services of the 4 residents who met the criteria for dental status and services. (Resident #D) Findings include: Resident #D was observed on 8/16/11 at 8:07 a.m. The resident had an offensive mouth odor and her teeth appeared to be in poor condition. There were no teeth on top and she had only a few teeth on the bottom, the teeth were discolored. Interview with the resident's daughter on 8/15/11 at 4:25 p.m., indicated the resident's natural teeth were in poor condition. The record for Resident #D was reviewed on 8/16/11 at 2:20 p.m. The	F0250	1. Immediate action was taken for Resident D. The dental referral was acted upon and referral has been made. 2. Other residents were identified by review of Resident records to ensure compliance with this requirement. 3. The system in place is one in which Social Services will follow up with nursing when a resident receives a dental referral to make sure appointments are set up in a timely manner. Social Service will review referral list after dental visit and follow up with nursing to ensure appointment is made. 4. The systemic changes will be monitored by the Administrator / designee who will audit three records a week for one month to ensure compliance with this requirement. Following the first month, audits will be conducted on a quarterly basis by the Administrator/designee until 100% compliance with this requirement. Results will be shared with the quality assurance committee on a monthly basis for three months.	09/22/2011

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	resident had diagnoses which included, but were not limited to, Alzheimer's disease, dementia and anxiety. A dental evaluation, dated 5/4/11, was reviewed. The evaluation indicated, "Pt (patient) is in pain in area #22. DDS (dentist) recommends all remaining teeth to be extracted, referral written, teeth broken and decayed pt states broken teeth hurt, points in area #22. Rec (recommend) ext (extract) all remaining teeth." Review of the nursing progress notes and the social service progress notes dated 5/4/11 through 8/16/11, indicated no attempts were made to arrange for a dentist or an oral surgeon to extract the resident's teeth. Interview with the Social Service Assistant on 8/17/11 at 9:34 a.m. indicated she had copies of all referrals made by the dentist. She indicated she does not follow up with the referral, or document that a referral was made. She indicated the nursing staff sets up appointments for the dental referrals. She provided a copy of a form titled, "Facility Notification of Dental Referral" that was dated 5/4/11. It indicated			

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	Resident #D was recommended to have extraction of all remaining lower teeth. Interview with the 200 South Unit Manager on 8/17/11 at 12:30 p.m., indicated the dental referral for teeth extraction was never arranged. Interview with Social Service Director on 8/22/11 at 9:20 a.m., indicated there had been no arrangements made for Resident #D to have her remaining teeth extracted. 3.1-34(a)			
F0253 SS=C	The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Based on observation and interviews, the facility failed to ensure the resident's environment was clean and in good repair related to chipped paint, marred and gouged walls/doors, short overbed light cords, stained privacy curtains and ceiling tiles, and torn wall paper on 3 of 3 Nursing units and 3 of 3 dining rooms, (The North, South, and PCU units) (The Main, PCU, and South unit Dining Rooms) This had the potential to affect 125 residents who resided in the facility.	F0253	1. Immediate action was taken for all resident rooms cited in this deficiency and are in process of having repairs completed by 9/22/112. Other rooms will be identified using a resident room Bi-weekly preventative Maintenance checklist. Any issues identifed will be placed on a priority list and scheduled for repairs.3 A system will be put into place whereby maintenance personnel and/or designee will check a sample of rooms to ensure compliance with this requirement. Any concerns will be noted and placed on the priority list. 4. The corrective action will	09/22/2011

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	Findings include: 1. During the Environmental Tour on 8/19/11 at 1:00 p.m., the following was observed on the North unit: a. The walls were marred and scratched next to the second bed in room 109. Two residents resided in this room. b. The paint on the base of the overbed table in the second bed in room 115 was chipped. Two residents resided in this room. c. The arms on the chair in room 117 were marred and scratched. The paint on the base of the overbed table for the first bed was chipped. Two residents resided in this room. d. There was a missing towel bar in the bathroom of room 128. Two residents resided in this room. e. There were dark colored stains on the privacy curtain around the first bed in room 130. The base of the closet door was marred and scraped. The wall paper was peeled off in an area by the soap dispenser in the bathroom. One resident resided in this room.		be monitored by By using an audit tool every two weeks for three months and monthly thereafter. Any issues identified will be communicated in the Quality Assurance meeting. AddendumThe main dining room, chipped paint on the wall under the sink counter was painted. The chipped paint on the North wall by the window was painted. The chipped paint on the window frame where the meal trays were served was painted and a wall guard was added that has corner guards.The special care unit dining room, the paint chipped on the door frame in the dining room was painted. The rust colored stains on the ceiling were painted.	

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	When interviewed at this time, the Housekeeping Supervisor and the Maintenance Supervisor indicated the above areas were in need of cleaning or repair. 2. During the Environmental tour on 8/19/11 at 1:22 p.m., the following was observed in the Main Dining Room: a. The paint was chipped on the wall under the sink counter. There was an area of chipped paint on the North wall by the window. The paint was chipped on the window frame where the meal trays were served from the kitchen. When interviewed at this time, the Housekeeping Supervisor and the Maintenance Supervisor indicated the above areas were in need of cleaning or repair. 3. During the Environmental Tour on 8/19/11 at 1:30 p.m., the following was observed on the South Unit: a. The closet door in room 214 was rusty. The walls in the bathroom were marred and there was a gauge in the wall by the handle bar. One resident resided in this room.			

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	b. There was a gauged area in the wall in the bathroom near the grab bar in room 216. The paint and plaster were chipped. The area was approximately 3 inches x 1 inch. Two residents resided in this room. c. The walls in the bathroom in room 222 were marred. Two residents resided in this room. d. There was a section of torn wallpaper near the head of the first bed in room 204. Two residents resided in this room. e. The paint on the door in the Central Bath on the unit was peeling on the corner. A total of 49 residents resided on the South Unit. f. The paint was chipped on the door frame in the dining room on the SCU section of the South Unit. There were rust colored stains on the ceiling. Sixteen residents resided on the SCU hall of the South Unit. When interviewed at this time, the Housekeeping and Maintenance Supervisors indicated the above areas were in need of cleaning or repair. 4. During the Environmental tour on			

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	8/19/11 at 1:43 p.m., the following was observed on the PCU unit: a. The paint on the bathroom door frame in room 310 was chipped. Two residents resided in this room. b. The string attached to the over bed light over the first bed in room 328 was not long enough to be reached from the bed. One resident resided in this room. When interviewed at this time, the Housekeeping Supervisor and the Maintenance Supervisor indicated the above areas were in need of cleaning or repair. 3.1-19(f)			

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F0278 SS=E	The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. Based on observation, record review and interview, the facility failed to ensure the resident's comprehensive assessment was accurate related to dental, height, weight, falls, vaccines, and diagnoses for 5 of 21 comprehensive assessments reviewed in the Stage 2 sample of 38. (Residents #63, #C, #D, #E, & #H) Findings include:	F0278	1. Immediate action was taken whereby, Resident #63 MDS dated 7/4/11 was corrected and submitted for transmission. Resident #H MDS dated 5/3/11, 5/7/11, 6/25/11 and 7/23/11 were corrected and transmitted. Resident #E MDS dated 8/3/11 was corrected and transmitted. Resident #D MDS dated 7/20/11 was corrected and transmitted and the correct height was obtained during survey. Resident #C MDS dated 8/9/11 was corrected and submitted.	09/22/2011

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	1. The record for Resident #63 was reviewed on 8/17/11 2:33 p.m. The resident was admitted to the facility on 6/26/11. Review of the weight record indicated the resident weighed 112 pounds on admission. Review of the Admission Nurses Assessment dated 6/26/11, indicated the resident's weight was 112 pounds. The Minimum Data Set (MDS) dated 7/4/11, indicated the recorded weight was 137 pounds with no weight loss. Interview with the Dietary Food Manager on 8/17/11 at 4:55 p.m., indicated she obtained that weight of 137 pounds from the hospital notes rather than the Nurses Admission Assessment. 2. The record for Resident #H was reviewed on 8/17/11 at 8:23 a.m. The resident's diagnoses included, but were not limited to gait difficulty secondary to lumbar compression, and fracture right humerus. Review of the Nurses Admission Assessment dated 4/26/11, indicated she had her own teeth with broken and carious.		2. Other residents will be identified through a chart audit of residents who have had a MDS in the last 30 days. Any inaccuracies as a result of this audit affecting reimbursement will be corrected and resubmitted per RAI guidelines. 3. The system in place will be reviewed by inservicing MDS and dietary regarding MDS accuracy and coding. 4. The corrective action will be monitored by MDS, dietary/ designee who will audit three MDS assessments twice per week until 100% compliance is met. Results will be reviewed in monthly Quality Assurance Meetings.	

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	Review of Nurse's Notes dated 5/4/11, 5/14/11, 6/7/11, and 7/7/11 indicated the resident had unwitnessed falls and was found on the floor in her room. Review of the initial MDS assessment dated 5/3/11, indicated the resident had no broken or loose teeth. Review of the following MDS assessments indicated the resident had no falls prior to the last assessment: 14 day medicare assessment dated 5/7/11, 60 day medicare assessment dated 6/25/11, and the quarterly assessment dated 7/23/11. Interview with the MDS Coordinator #2 on 8/18/11 at 11:46 a.m., indicated she was not aware the resident had any broken or loose teeth at the time of the initial MDS assessment. She also indicated at the time, the falls were not coded correctly on all of the MDS assessments. 3. The record for Resident #E was reviewed on 8/16/11 at 3:20 p.m. The August 2011 Physician Order Sheet indicated the resident had diagnoses that included, but were not limited to, diabetes, hemiplegia, anemia, seizures and schizophrenia.			

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	Review of the resident's immunization form indicated the resident had received the pneumococcal vaccine on 12/13/10. Review of the Quarterly MDS (Minimum Data Set) assessment, completed on 8/3/11, indicated the pneumococcal vaccine was not offered. The MDS also indicated the resident did not have a diagnosis of schizophrenia. Interview with MDS Coordinator #2 on 8/19/11 on 10:05 a.m. indicated the MDS was not accurately coded. She indicated the MDS did not have the current diagnosis of schizophrenia coded. Interview with MDS Coordinator #1 on 8/19/11 at 10:30 a.m., indicated the MDS did not have the same information as the immunization record. 4. The record for Resident #D was reviewed on 8/16/11 at 2:20 p.m. The resident had diagnoses the included, but were not limited to, Alzheimer's disease, dementia and anxiety. The resident's immunization record was reviewed. It indicated the resident reviewed the pneumococcal vaccine			

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	on 11/2/10. Review of the Quarterly MDS, completed on 7/20/11, indicated the pneumococcal vaccine was not offered. The MDS also indicated the resident was 68 inches in height. Interview with MDS Coordinator #1 on 8/19/11 at 10:30 a.m., indicated the MDS did not have the same information as the immunization record. Observation on 8/17/11 at 9:44 a.m., indicated the resident was not 68 inches in height. Interview with MDS Coordinator #2 at that time, indicated the resident was not 68 inches in height and the MDS was inaccurately coded On 8/17/11 at 10:15 a.m., interview with the 200 South Unit Supervisor indicated she had measured the resident's height. She indicated the resident was 64 inches tall. 5. The record for Resident #C was reviewed on 8/16/11 at 2:40 p.m. The resident had diagnoses that included, but were not limited to, cancer of the rectum and diabetes. The resident's immunization record			

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	indicated the resident received the pneumococcal vaccine on 12/7/10. Review of the Quarterly MDS, completed on 8/9/11, indicated the pneumococcal vaccine was not offered to the resident. Interview with MDS Coordinator #1 on 8/19/11 at 10:30, indicated the MDS did not have the same information as the immunization record. 3.1-31(g)			
F0279 SS=D	A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on observation, record review and interview, the facility failed to ensure a care plan was initiated	F0279	1. Immediate action was taken whereby Resident #32 care plan was initiated and reviewed. Resident #B unable to correct as	09/22/2011

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	related to range of motion for 1 of 3 residents of the 8 who met the criteria for limited range of motion. The facility also failed to ensure a nutritional care plan was initiated for 1 of 3 residents of the 7 who met the criteria for weight loss. (Residents #B and #32) Findings include: 1. On 8/16/11 at 3:10 p.m., Resident #32 was observed in her room in her bed sleeping. The resident's legs were bent at the knees bilaterally. On 8/18/11 at 2:25 p.m., the resident was observed in her room sleeping. The resident was positioned on her left side and her legs were bent at the knees. On 8/19/11 at 10:45 a.m., the resident was taken to her room by Restorative CNA #1. The CNA indicated the resident was on the restorative case load for grooming and pivot transfers. She also indicated they would sometimes work with the resident's legs. When asked, the resident was able to open her hands and extend her fingers. The Restorative CNA then proceeded to extend the resident's legs, she indicated the		resident was discharged from the facility at the time of this alleged finding. 2. Other residents will be identified by a Clinical record audit for anyone in a restorative program and/or triggering for weight loss in the last six months. Care plans will be updated as identified through the audit. 3. The system in place will be reviewed by conducting staff inservices for restorative and dietary regarding initiating care plans. 4. The system will be reviewed by MDS and Dietary or Designee who will meet weekly and review six care plans per week to ensure a care plan is in place for weight loss and restorative. This will be completed for three months and reviewed at monthly QA.	

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	resident was only able to extend her legs to about a 30 degree angle. The Restorative CNA, indicated the resident's legs had been that way for awhile. The record for Resident #32 was reviewed on 8/16/11 at 3:15 p.m. The resident's diagnoses included, but were not limited to, history of falls, contractures of lower leg joint, and arthritis. The Quarterly Minimum Data Set Assessment (MDS) dated 7/25/11, indicated the resident had a functional limitation in range of motion. The MDS indicated the resident had impairment on both sides of the upper extremity (shoulder, elbow, wrist, hand) and both sides of the lower extremity (hip, knee, ankle, foot). The plan of care dated 7/29/11, indicated there was no current care plan for limitation in range of motion and/or restorative nursing. Interview with the North Unit Manager on 8/22/11 at 2:30 p.m., indicated the resident did not have a current care plan related to restorative nursing or range of motion. 2. The closed record for Resident #B was reviewed on 8/18/11 at 8:35 a.m.			

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	The resident was admitted to the facility on 2/25/11. The resident's admission weight was 175 pounds on 2/25/11. The resident was in and out of the hospital with the last hospital admission from 4/23/11 and returned on 5/11/11. At the time of readmission to the facility the resident weighed 144 pounds on 5/15/11. Review of the significant change assessment Minimum Data Set (MDS) assessment dated 5/18/11 indicated the resident's weight was 144 pounds and there was a significant weight loss of 5% or more in the last month or 10% or more in the last six months. Review of the current plan of care, updated on 5/19/11, indicated there was no care plan for weight loss. Interview with the South Unit Manager on 8/18/11 at 2:25 p.m., indicated there was no care plan developed for the resident's weight loss. 3.1-35(a)			

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F0282 SS=E	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, record review and interview, the facility failed to ensure physician's orders and/or the plan of care were followed as written related to alarms and non-skid footwear not in use for 3 of 3 residents of the 5 who met the criteria for accidents. The facility also failed to ensure laboratory orders were obtained in a timely manner for 6 of 10 residents in the Stage 2 Sample of 38 who were reviewed for unnecessary medications. The facility also failed to ensure splints were on as ordered for 1 of 3 residents of the 8 who met the criteria for limited range of motion. The facility also failed to ensure medications were reduced for 1 of 10 residents in the Stage 2 Sample of 38 who were reviewed for unnecessary medications. The facility also failed to ensure medications were initiated in a timely manner for 1 of 1 resident of the 3 whose families were interviewed. (Residents #B, #C, #D, #E, #F, #G, #H, #J and #K) Findings include: 1. On 8/17/11 at 8:08 a.m., Resident	F0282	1. Immediate action was taken for Resident F. Non-skid footwear was applied immediately. Interdisciplinary team met related to Resident F and Discontinued non-skid footwear as an ineffective intervention.Immediate action was taken for Resident H. interventions were reviewed on the date of this finding and with resident request, alarm sensor was removed and other interventions were put into place. The urine sample was collected but unable to correct due to event happening in the past.Immediate action was taken for Resident J who was placed in the correct wheelchair with correct interventions in place. The urine sample was collected but unable to correct due to event happening in the past.Immediate action was taken for Resident B. Unable to correct as resident was discharged from the facility.Immediate action was taken for Resident K. MD and family were notified during survey. Lab was obtained. Immediate action was taken for Resident G. Lab was obtained. MD and family made aware of result. Licensed staff received counseling on failure to transcribe orders properly. Immediate action was taken for Resident E. Licensed therapist completed screen on	09/22/2011

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	#F was observed in a broda chair seated in the hall across from the nurses' station. The resident was wearing no shoes and had white socks on his feet. On 8/18/11 at 12:44 p.m. and 1:33 p.m., the resident was again observed in his broda chair. The resident had no shoes on and white socks on his feet. On 8/19/11 at 8:23 a.m., the resident was observed in his room in the broda chair. The resident had white socks on his feet and no shoes. At 11:00 a.m., the resident was observed in the broda chair in the main dining room. A pillow was observed on the footrest. The resident was wearing no shoes and was wearing white socks. The record for Resident #F was reviewed on 8/16/11 at 2:38 p.m. The care plan dated 6/17/11, indicated the resident was at risk for falls related to history of falls, and history of leaning over to left side while in bed. One of the approaches indicated staff were to ensure proper fitting shoes or non skid footwear were in use. Interview with CNA #5 on 8/22/11 at 9:25 a.m., indicated the resident had a history of rolling out of bed. She		the day of this finding and the following day to ensure that there was no decline in range of motion. Splint applied. MD made aware of missing lab. New orders given and received. Resident on correct dosage for psychotropic medication. Unable to correct for timeliness due to event happened in the past. Immediate action was taken to review Resident C. However, unable to correct as event occurred in the past. Immediate action was taken to review Resident D. However, unable to correct as event occurred in the past. The infection noted in this alleged finding has resolved. 2. Residents will be identified by a 100% audit of resident clinical records which will be completed to check for fall devices, labs for the past thirty days, residents with use of splints, residents with psychtropic medication reductions for the past thirty days. Any findings corrected at the time of audit. 3. The system in place will be reviewed by Nursing staff inservices to be held regarding devices for fall prevention, splint use, obtaining labs in a timely manner, medication administration in a timely manner, medication reductions in a timely manner. An audit tool has been developed to address devices for fall prevention, splint use, obtaining labs in a timely manner, medication administration in a timely manner, medication	

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	further indicated when the resident was gotten up in the broda chair, a pillow was put on the foot rest and the chair reclined slightly. Interview with the North Unit Manager on 8/22/11 at 10:37 a.m., indicated the resident was a fall risk but the intervention for non-skid footwear was not appropriate for the resident due to he does not walk and the care plan needed to be updated. 2. On 8/15/11 at 3:25 p.m., Resident #H was observed laying in bed. While walking up to the resident's bed and sitting in the arm chair next to bed, there was no evidence a sensor alarm was sounding or turned on by the resident's bed. On 8/16/11, at 2:22 p.m., the resident was out of her room. While walking around her room and around the resident's bed, there was no evidence a sensor alarm was not turned on and functioning. On 8/17/11 at 4:12 p.m., the resident was observed sitting on the side of her bed, while approaching her and standing approximately one foot from her bed, the sensor alarm did not		reductions in a timely manner.4. The system will be monitored by the Unit Manager / designee who will do a random audit three times per week for three months, then quarterly thereafter, to ensure fall devices are in place and working, splints are applied properly, labs and medication administraton are done in a timely manner. The results of the audit will be forwarded to the QA Committee for their review and any concerns will be addressed. AddendumThe unit manager will audit 5 residents three times per week for three months, then quarterly thereafter.	

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	sound. Further observation at that time, indicated the PCU Unit Manager entered the room and turned a switch on the sensor alarm that was located on the wall parallel to the resident's bed. The alarm immediately sounded. CNA #1 was observed to come into the room, she indicated that she did not know what the device was on the wall, and she had not idea what a sensor alarm was. Interview with LPN #1 on 8/17/11 at 4:22 p.m., indicated she had no idea Resident #H used a sensor alarm. Interview with LPN #2 on 8/17/11 at 4:24 p.m., indicated she was the nurse taking care of the Resident #H and she had no idea the resident had a sensor alarm in place. The record for Resident #H was reviewed on 8/17/11 at 8:23 a.m. Review of the current plan of care plan dated 6/7/11, indicated the resident had the potential for fall related to a history of falls and an unfamiliar environment. The nursing approaches were to have sensor alarm, and a bed and chair alarm. Interview with the PCU Unit Manager on 8/17/11 at 4:30 p.m., indicated the			

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	sensor alarm was to be in place after the resident had fractured her elbow. Review of Physician orders dated 7/27/11, indicated urinalysis with a culture and sensitivity. Review of the Lab results indicated the urine was not obtained until 7/29/11. Review of Nursing Progress Notes dated 7/27 and 7/28/11, indicated there was no documentation of why the urine was not collected timely. Interview with the PCU Unit Manager on 8/19/11 at 9:44 a.m., indicated the nurse who took the order for the urinalysis folded the order over with the intentions of transcribing it and following it through. However, the chart was placed back into the drawer and the orders were not carried out until 7/29/11. 3. On 8/17/11 at 4:00 p.m. Resident #J was observed up in a wheelchair. There was a chair alarm noted to the chair, and there was a chair cushion on the bottom of the chair. On 8/17/11 at 4:13 p.m., CNA #1 was observed in the resident's room, at that time, she indicated she placed			

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	the resident in the wheelchair that she was currently sitting in. The CNA indicated she had thought this was the Resident #J's wheelchair. Further observation at the time, indicated the CNA was asked to stand Resident #J up from the chair. The PCU Unit Manager and CNA #1 then stood the resident up from the wheelchair. The chair alarm did not sound. Further observation indicated the chair alarm was turned off. There was also no dycem noted on top of the cushion or under the cushion in the wheelchair. The record for Resident #J was reviewed 8/17/11 at 3:30 p.m. The current plan of care dated 6/17/11, indicated the resident was at risk for falls. The nursing approaches were to have bed and wheelchair alarm and a dycem to the wheelchair. Review of Physician orders dated 1/20/11, and on current 8/11 recap, indicated bed and wheelchair alarm check function and placement every shift. **Interview with the PCU Unit Manager on 8/17/11 at 4:30 p.m., indicated the resident was to have**			

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	wheelchair alarm and a dycem to under her cushion while up in the wheelchair. Further review of Physician orders dated 7/14/11, indicated to obtain urinalysis with a culture and sensitivity may straight cath. Review of the Lab results indicated the urine was not collected until 7/19/11 (five days later). Interview with LPN #3 on 8/22/11 at 10:13 a.m., indicated she was the nurse who usually works down on the unit with Resident #J. She indicated she was not working when the lab was ordered and written. She further indicated if staff were unable to obtain the urine sample then the Physician should have been notified. Interview with PCU Unit Manager on 8/22/11 at 10:13 a.m., indicated the 24 hour report indicated the urine was collected and placed in the fridge on 7/17/11, however the lab has only 24 hours to pick up. She indicated the lab must not have picked it up timely so they had to collect another one. 4. The closed record was reviewed for Resident #B on 8/18/11 at 8:35			

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	a.m. Review of Physician Orders dated 2/25/11, indicated an urinalysis weekly times three weeks. The Physician's order was clarified on 3/4/11 indicating order urinalysis weekly on Fridays. Review of the Laboratory findings indicated there was no urine collected in March or April 2011. Interview with the South Unit Manager on 8/18/11 at 2:22 p.m., indicated the facility only collected two urine samples from the resident during her entire stay. There were no samples collected in March or April 2011. **5. The record for Resident #K was** reviewed on 8/17/11 at 3:30 p.m. Review of the current Physician orders on the 8/11 recap indicated a Complete Blood Count (CBC) monthly. Review of the lab results dated 8/3/11, indicated the resident's Hemoglobin was 9.0 a low level. Further review on the bottom of the lab indicated the physician was notified and new orders to draw a			

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	CBC was to be done in one week. Review of the Lab results indicated there was no CBC completed on 8/10/11 or thereafter. Interview with the PCU Unit Manager on 8/19/11 at 1:23 p.m., indicated the CBC results were called to the physician, however, the nurse taking the telephone order did not transcribe it onto Physician orders, nor did she fill out a requisition for the lab to be drawn in a week. 6. The record for Resident #G was reviewed on 8/16/11 at 2:25 p.m. The resident was admitted to the facility on 8/4/11. The resident's diagnoses included, but were not limited to, diabetes mellitus and cerebral vascular accident (stroke). Review of the 8/4/11 admission orders indicated there was an order written for HgbAIC (a blood test to check blood sugars levels over a period of time) laboratory test to be completed on 8/10/11 and then every three months. Review of the 8/11 laboratory test results indicated a HgbAIC test had not been completed on 8/10/11 as ordered by the physician. When interviewed on 8/22/11 at 8:32 a.m., the facility Nurse Consultant #1			

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	indicated nursing staff did not complete a requisition for the test to be completed and the laboratory did not complete the test as there was no requisition. 7. Resident #E was observed on 8/16/11 2:16 p.m. The resident was seated in her wheelchair in her room. There was no splint on her right wrist. On 8/16/11 at 3:59 p.m., the resident was observed seated in her wheelchair. There was no splint on the resident's right wrist. Continued observations on 8/17/11 at 9:41 a.m., 10:00 a.m. and 2:00 p.m., indicated there was no splint on the resident's right wrist. On 8/18/11 at 7:55 a.m. and at 2:07 p.m., the resident was observed with no splint on her right wrist. The resident was observed on 8/18/11 at 2:23 p.m. The resident did not have a splint on her right wrist. Interview with MDS Coordinator #2 on 8/18/11 at 2:23 p.m., indicated there was no splint on the resident's right wrist. The record for Resident #E was reviewed on 8/16/11 at 3:20 p.m. The resident had diagnoses that included,			

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	but were not limited to, diabetes, hemiplegia, anemia, seizures and schizophrenia. The Quarterly MDS (Minimum Data Set) assessment, completed on 8/3/11, was reviewed. The assessment indicated the resident had functional limitations in range of motion on both upper extremities. A care plan, dated 8/5/11, indicated the resident had a potential for decline in passive range of motion related to decreased mobility. One of the interventions was to have left and right hand splints on as ordered. A care plan, dated 8/5/11, indicated the resident needed splinting to her bilateral wrists related to decreased mobility. The goal was to wear splints to her bilateral wrists 6 times per week. The interventions to be used included: -apply splint in a.m. take off in p.m. -explain procedure to resident -monitor splint area for skin integrity and cleanliness -notify nurse of any changes -perform range of motion to extremity for splint application			

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	Interview on 8/18/11 at 2:23 p.m., with Restorative CNA #4, indicated she had not applied any splint to the resident's right wrist. She indicated therapy discontinued the use of the resident's splint for her right wrist. She indicated that she applied a wrist splint to the resident's left hand when the resident was up in the chair and placed the white palm protector in the left hand when the wrist splint was removed. Interview with the resident on 8/18/11 at 2:25 p.m., indicated she had not used any splint on her right wrist. Interview with MDS Coordinator #1 on 8/18/11 at 2:15 p.m., indicated the resident did not have splints to both her right and left wrists as indicated on the resident's care plan. The June 2011, July 2011 and the August 2011 Physician Order Sheets for Resident #E were reviewed. There were physician's orders for a monthly CBC (complete blood count) and a biweekly Dilantin (a medication used for seizures) level to be drawn. A Dilantin level was obtained on 7/14/11, there was not another Dilantin level obtained until 8/10/11.			

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	Interview with the 200 South Unit Manager on 8/22/11 at 1:30 p.m., indicated the Dilantin levels were not drawn bi-weekly as ordered by the physician. The CBC results were reviewed. There were results for CBC levels that were obtained on 8/10/11 and 7/13/11. There were no CBC results for the month of June 2011. Interview with the 200 South Unit Manager on 8/19/11 at 2:02 p.m., indicated a CBC was not drawn in June 2011 as ordered by the Physician. A form titled "Consultant Report" with Resident #E's name and dated 2/2/11, was reviewed. The pharmacist had recommended that the resident's Risperdal (an anti-psychotic medication) be reduced from 2 mg (milligrams) twice daily. The recommendation was to change the Risperdal to 2 mg in the a.m. and 1 mg in the p.m. The physician signed the form on 3/8/11 and indicated that he accepted the recommendation and wanted the medication to be reduced. Review of the physician's orders			

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	indicated the recommendation was not followed through until 4/7/11. There was a physician order dated 4/7/11 that indicated to discontinue the Risperdal 2 mg twice daily and to start Risperdal 2 mg at 9:00 a.m. and 1 mg at 5:00 p.m. Interview with the 200 South Unit Supervisor on 8/18/11 at 1:57 p.m., indicated the physician's order to reduce the Risperdal was not followed through timely. She indicated the medication should have been reduced on 3/8/11 when the physician signed the consultant report. 8. The record for Resident #C was reviewed on 8/16/11 at 2:40 p.m. The resident had diagnoses that included, but were not limited to, cancer of the rectum and diabetes. There was a physician order, dated 4/1/11, that indicated "May straight cath (catheterize) resident for ua (urinalysis) if unable to void." Review of the laboratory tests indicated a urinalysis was not obtained until 4/8/11, seven days after the physician ordered the urinalysis to be obtained. Interview with the 200 South Unit Manager on 8/21/11 at 9:15 a.m. indicated the urine sample was not			

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	obtained timely as ordered by the physician. 9. The record for Resident #D was reviewed on 8/16/11 at 2:20 p.m. An entry in the nursing progress notes, dated 8/2/11 at 3:30 p.m., indicated, "...daughter complains of mouth odor, writer assessed resident , coated tongue, with foul odor noted, no complaints of pain at this time...." The physician was notified on 8/2/11 of the resident's oral status. There was a physician order, dated 8/2/11, that indicated, "Nystatin (an antifungal medication) solution 10 cc (cubic centimeters) po (by mouth) swish and swallow bid (twice daily) x 14 days." A nursing progress note, dated 8/5/11 at 2:12 p.m., indicated, " ...writer notes calling pharmacy due to medication nystatin solution not deliver at this time, writer notes speaking to pharmacy tech, and did receive statement of not receiving physician order for the nystatin solution, pharmacy tech did request writer to read order to the pharmacy tech and did receive statement that the nystatin solution well be send out with other medications tonight [sic]...."			

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	Observation on 8/18/11 at 8:33 a.m., indicated the label on the Nystatin medication bottle was dated 8/5/11. Interview with LPN #4 at that time, indicated the medication was delivered on 8/5/11. Interview with the 200 South Unit Manager on 8/17/11 at 12:30 p.m., indicated the Nystatin was ordered on 8/2/11. She also indicated the medication was not initiated timely. 3.1-35(g)(2)			
F0312 SS=D	A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, record review and interview, the facility failed to provide the necessary services for residents requiring assistance with activities of daily living related to oral hygiene and grooming for 2 of 3 residents reviewed of the 9 residents who met the criteria for activities of daily living. (Resident #D and Resident #E) Findings include: 1. Resident #D was observed on 8/16/11 at 8:07 a.m. The resident had	F0312	1. Immediate action was taken for Resident #D who was provided with oral care on the date of this finding. Immediate action was taken for Resident #E. Finger nails were trimmed on the date of this finding. 2. Other residents were identified through observation to ensure that oral care was given and nails were trimmed. Any issues identifed were addressed at the time of discovery.3. The system in place will be reviewed during inservice training to be held with all nursing staff on ADL care. 4. The corrective action will be monitored by utilizing a quality	09/22/2011

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	an offensive mouth odor and her teeth appeared to be in poor condition. There were no teeth on top and she had only a few teeth on the bottom, the teeth were discolored. Interview with the resident's daughter on 8/15/11 at 4:25 p.m., indicated the resident's natural teeth were in poor condition. On 8/17/11 at 7:43 a.m. CNA #3 was observed providing morning care for the resident. The CNA washed the resident. She then assisted the resident with dressing. Oral care was observed. The CNA poured a small amount of mouthwash into a glass. She then instructed the resident to put some of the mouthwash in her mouth, rinse and then to spit it out into the sink. The CNA did not use a toothbrush and toothpaste for oral care, she did not brush the resident's teeth. CNA #3 was interviewed on 8/17/11 at 7:50 a.m. She indicated she used only mouthwash for oral care, she indicated the resident had only few teeth and did not like having them brushed. She indicated that at times in the past, she had used a swab on the resident's teeth.		assurance tool. Social service/designee will observe 5 residents per week for three months then quarterly until compliance is met to ensure residents are provided with oral care and trimmed nails. The results of the audit will be forwarded to the QA Committee and any concerns will be addressed.	

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	The record for Resident #D was reviewed on 8/16/11 at 2:20 p.m. The resident had diagnoses the included, but were not limited to, Alzheimer's disease, dementia and anxiety. The Quarterly MDS (Minimum Data Set) assessment, completed on 7/20/11, indicated the resident required extensive assistance of 2 staff members for personal hygiene. There was a care plan, dated 7/22/11, that indicated the resident had an ADL (Activity of Daily Living) self care performance deficit related to dementia. The goal indicated the resident would maintain current level of function through the next review date. Interventions included: -praise all efforts at self care -staff to assist as needed -encourage the resident to participate to the fullest extent possible with each interaction The policy titled "Oral Care" and revised on 4/2005, was provided by the 200 South Unit Supervisor on 8/18/11 at 1:15 p.m. She indicated the policy was current. The policy indicated: Purpose:			

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	1. To clean and freshen the resident's mouth 2. To prevent infections in the mouth 3. To stimulate the gums and remove food particles from between the teeth. Procedure: Wet the toothbrush and put on a small amount of toothpaste. First, brush the upper teeth and then the lower teeth. Interview with the 200 South Unit Supervisor on 8/18/11 at 1:15 p.m., indicated the CNA's were to brush the resident's teeth with a toothbrush and toothpaste for complete oral care. She indicated the CNA should have used a toothbrush to clean Resident #D's teeth during morning care. 2. Resident #E was observed on 8/15/2011 at 2:12 p.m. The resident's fingernails on her left hand were long and were in need of trimming. The record for Resident #E was reviewed on 8/16/11 at 3:20 p.m. The resident had diagnoses the included, but were not limited to diabetes and hemiplegia. The Quarterly MDS, completed on 8/3/11, indicated the resident was			

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	dependent on one staff member for personal hygiene. Review of the social service progress notes, dated 3/2/11 through 8/2/11, indicated there was no documentation that the resident refused to have fingernails trimmed or that she preferred to have long fingernails. There was no care plan for resisting assist with nail trimming or indicating a preference for long nails. There was a care plan, dated 8/5/11, that indicated the resident had an ADL self care performance deficit related to generalized weakness. The resident's goal was to remain clean and neat through the next review and participate as able. Interventions were listed as: - praise for all efforts at self care -Physical Therapy and Occupational Therapy evaluation and treatment as per physician order -encourage the resident to participated to the fullest extent possible with each interaction -encourage the resident to use bell to call for assistance Interview with the resident on 8/17/11 at 2:00 p.m., indicated staff had cut			

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	the resident's fingernails that morning, she indicated she could not cut her own fingernails. Interview with CNA #2 on 8/19/11 at 10:30 a.m., indicated the resident was a diabetic and CNA's could not cut the fingernails of a diabetic resident, she indicated when long fingernails are observed, the CNA informs the nurse. The CNA indicated the resident does not refuse to have her fingernails cut. Interview with LPN #4 on 8/19/11 10:40 a.m., indicated there was no schedule for nail cutting for diabetic residents. He indicated fingernails of the diabetic residents were cut when they were observed to be long or when the CNA reported that nails were long and in need of trimming. The Social Service Assistant was interviewed on 8/19/11 at 11:40 a.m. She indicated the resident had not refused to have her fingernails trimmed. On 8/22/11 at 12:15 p.m., the 200 South Unit Manager was interviewed. She indicated the nurse's were responsible for trimming the nails of the diabetic residents. 3.1-38(a)(3)(C)			

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	3.1-38(a)(3)(E)			
F0315 SS=G	Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on record review and interviews, the facility failed to ensure the resident received the necessary treatment and services to treat an urinary tract infection when a resident was exhibiting signs and symptoms of an urinary tract infection for 1 of 3 residents reviewed for urinary tract infections of the 3 who met the criteria for urinary tract infections. Findings include: The closed record was reviewed for Resident #B on 8/18/11 at 8:35 a.m. The resident's diagnoses included, but were not limited to, multiple sclerosis, seizures, pneumonia, and neurogenic bladder. The resident was admitted to the facility on 2/25/11. The resident was admitted to the hospital on 4/23/11 and returned to the facility on 5/11/11 with	F0315	1. Immediate Action could not be taken for Resident B as the the resident had been discharged from the facility. 2. Other residents having the potential to be affected were identified by lab reports from the last thirty days indicating residents with urinary tract infections. Those residents charts with indwelling catheters were audited to ensure appropriate treatments and services were in place to prevent urinary tract infections. Any abnormal findings were reported to MD and family.3. The system in place will be reviewed with Nursing staff by inservice training related to obtaining labs, signs, symptoms and treatment of urinary tract infections. An audit tool will be utilized to ensure urine samples are collected and sent to lab with MD and family notification of results. 4. The system will be monitored by the Director of Nursing/designee by auditing five charts per week for three months	09/22/2011

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	an indwelling foley catheter. The 5/26/11 catheterization evaluation indicated the resident had the diagnoses of neurogenic bladder/atonic bladder and the resident was to have a catheter indefinitely due to multiple sclerosis. Review of Physician Orders dated 5/11/11, indicated urinalysis every week for three weeks then monthly. Review of the laboratory data indicated the first urinalysis obtained was not until 5/23/11. The final culture dated 5/27/11 indicated greater than 100,000 entercoccus faecium. The organism was resistant to vancomycin and penicillin antibiotics. The organism was susceptible to tetracycline and linezolid antibiotics. Review of Nurses Notes dated 5/25/11, indicated the resident had a seizure and was sent out to the emergency room at 6:32 a.m. The resident returned to the facility on 5/25/11, at 3:00 p.m. with Physician orders for an antibiotic for an urinary tract infection. Review of Physician Orders dated 5/25/11, indicated Bactrim DS		and then quarterly thereafter until compliance has been met. The results of the audit will be forwarded to the QA committee for their review. The facility respectfully requests a face to face Informal Dispute Resolution (IDR) with respect to F-315G. The finding, cited at a G level scope and severity, is based on the perception that the omission of a urinalysis contributed to the resident's development of an infection. Additional information will be provided during the Informal Dispute Resolution (IDR) meeting that will show that the resident's infection was chronic and the omission of the urinalysis did not cause a negative outcome. We believe after consideration of the additional information, the Department will agree to a reduced scope and severity.	

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	800-160 milligrams (mg) one tab by mouth twice a day times seven days. Review of Nurse's Notes dated 5/27/11 indicated the resident's Physician was not made aware of the culture results of the 5/23/11 urinalysis. Review of the laboratory results indicated the next urinalysis obtained was on 6/7/11. The final culture was dated 6/8/11 which indicated 60,000 to 70,000 multiple gram positive organisms. The resident's physician was notified and no new orders were obtained. Nurses notes dated 7/7/11, at 8:09 p.m., indicated the resident's urine was cloudy and yellow in color with slight hematuria (blood in the resident's urine). Review of Physician orders dated 7/7/11, indicated to obtain an urinalysis with a culture and sensitivity. The next entry in Nurses Notes for an urine assessment was 7/8/11, at 1:55 a.m., which indicated the urine was yellow and cloudy with no odor or sediment in the tubing.			

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	The next entry for an urine assessment was on 7/8/11 at 3:31 p.m., which indicated the urine was yellow with no hematuria noted. The urine sample was in the refrigerator awaiting lab pick up. The next documentation about the resident's urine was not until 7/11/11 at 8:49 p.m., which indicated the urine was yellow with mucous threads noted. Nursing Progress Notes dated 7/17/11, at 9:08 p.m., indicated called to room at 8 p.m. by other staff due to change in level of consciousness, excessive frothy sputum in mouth. Resident found to be postictal (after seizing). Urinary output was decreased. The physician was notified and new orders were obtained to start an intravenous line with D5 .9 normal saline give 200 cubic centimeters (cc) bolus then 100 cc an hour thereafter. Urinary output was to be monitored. Another entry in Nursing Progress Notes was on 7/17/11 at 9:36 p.m., which indicated there was no urinary output and the intravenous fluids were infusing without problems. On 7/18/11 at 3:13 a.m. Nursing			

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	Progress Notes indicated the resident appeared lethargic and there was some yellow urine observed in the foley bag. On 7/18/11 at 4:30 p.m. Nursing Progress Notes indicated at 9 a.m., resident was lethargic and not responding and had a seizure which last over 20 minutes. The resident's physician was notified and new orders were obtained to send to the hospital. Review of the laboratory results indicated there were no results for urinalysis that was collected on 7/8/11 and placed in the refrigerator. Interview with South Unit Manager on 8/19/11 at 2:27 p.m., indicated she had called the lab and they indicated they did not receive an urine sample from the facility for Resident #B. Review of Physician orders dated 5/11/11 indicated to change the resident's foley catheter every two weeks. Review of the Medication Record for 6/11 indicated the foley catheter was changed on 6/3/11 and 6/24/11. Review of the 7/11 Medication Record indicated the foley catheter had not been changed from 7/1-7/18/11. Review of a urinalysis that was			

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	completed in the hospital on 7/18/11 indicated greater than 100 white blood cells, 1 plus bacteria, 2 plus blood, 20-50 red blood cells. The final urine culture was dated 7/20/11 which indicated 70-80,000 proteus mirabilis pipercillin and greater than 100,000 multiple gram positive organisms indicating an urinary tract infection. Interview with the South Unit Manager on 8/19/11 at 2:25 p.m., indicated the foley catheter was not changed every two weeks as ordered and was not changed in July 2011. She further indicated the facility only collected two urine samples from 5/11/11 and the one sample collected on 7/8/11 was not sent to the lab. The South Unit Manager also indicated at the time, the resident was sent out to the hospital on 7/18/11 and did not come back to the facility. 3.1-41(a)(2)			
F0318 SS=D	Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Based on observation, record review and interview, the facility failed to	F0318	1. Immediate action was taken for Resident #E. Licensed	09/22/2011

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	ensure residents who had a limitation in range of motion received services to prevent further decline in range of motion related to splints that were not applied as scheduled for 1 of 3 residents reviewed for contractures of 9 who met the criteria for contractures. (Resident #E) Findings include: Resident #E was observed on 8/16/11 2:16 p.m. The resident was seated in her wheelchair in her room. There was no splint on her right wrist. On 8/16/11 at 3:59 p.m., the resident was observed seated in her wheelchair. There was no splint on the resident's right wrist. Continued observations on 8/17/11 at 9:41 a.m., 10:00 a.m. and 2:00 p.m., indicated there was no splint on the resident's right wrist. On 8/18/11 at 7:55 a.m. and 2:07 p.m. the resident was observed with no splint on her right wrist. The resident was observed on 8/18/11 at 2:23 p.m. The resident did not have a splint on her right wrist. Interview with MDS Coordinator #2 on 8/18/11 at 2:23 p.m., indicated there		therapist completed screen on the day of this finding and the following day to ensure there was no decline in range of motion. 2. Other residents were identified by a re-screening of residents with splints to ensure appropriateness. 3. The system in place will be reviewed by an inservice with restorative staff on the application and monitoring of splint use. A checklist has been updated with the current list of residents requiring splints. Restorative aides will document the application of splints as ordered. 4. The system will by monitored by the unit manager or designee who will monitor three residents per week for application of splints as ordered. The results will be discussed in quality assurance meetings.	

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	was no splint on the resident's right wrist. The record for Resident #E was reviewed on 8/16/11 at 3:20 p.m. The resident had diagnoses that included, but were not limited to, diabetes and hemiplegia. The Quarterly MDS (Minimum Data Set) assessment, completed on 8/3/11, was reviewed. The assessment indicated the resident had functional limitations in range of motion on both upper extremities. A care plan, dated 8/5/11, indicated the resident had a potential for decline in passive range of motion related to decreased mobility. One of the interventions was to have left and right hand splints on as ordered. A care plan, dated 8/5/11, indicated the resident needed splinting to her bilateral wrists related to decreased mobility. The goal was to wear splints to her bilateral wrists 6 times per week. The interventions to be used included: -apply splint in a.m. take off in p.m. -explain procedure to resident -monitor splint area for skin integrity			

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	and cleanliness -notify nurse of any changes -perform range of motion to extremity for splint application Interview with MDS Coordinator #1 on 8/18/11 at 2:15 p.m., indicated the resident was to wear splints to both her right and left wrists as indicated on the resident's care plan. Interview on 8/18/11 at 2:23 p.m. with Restorative CNA #4, indicated she had not applied any splint to the resident's right wrist. She indicated therapy discontinued the use of the resident's splint for her right wrist. She indicated that she applied a wrist splint to the resident's left hand when the resident was up in the chair and placed the white palm protector in the left hand when the wrist splint was removed. Interview with the resident on 8/18/11 at 2:25 p.m., indicated she had not used any splint on her right wrist. She indicated she had the blue splint on her left wrist when up in the chair and the white palm protector on when in bed. The Occupational Therapist was interviewed on 8/18/11 at 2:30 p.m.			

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	She indicated the resident was to use a left resting dorsal hand splint during the day shift and a wrist cock up splint was to be applied to the right wrist during the day shift. She also indicated that when the left resting dorsal splint was off, the resident was to have a palm protector in place to maintain skin integrity. The form titled "Restorative Nursing Referral Form" and dated 2/24/11, was reviewed. It indicated the resident was to have a wrist cock up splint to her right hand. It was to be placed on the resident in the a.m. and removed in the p.m. The wearing schedule indicated, "wrist cockup right hand a.m. to p.m." The form was signed by the Restorative Nurse, the Restorative CNA and the referring clinician. Interview with the Occupational Therapist on 8/18/11 at 2:30 p.m., indicated the resident was not wearing the right wrist cock up splint as recommended by the therapist and as indicated to be worn on the resident's care plan. 3.1-42(a)(2)			

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F0323 SS=G	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review and interviews, the facility failed to ensure each resident was free from falls related to functioning wheelchair alarms and sensor alarms for 2 of 3 residents reviewed for accidents of the 5 residents who met the criteria for accidents. This resulted in Resident #H fracturing her humerus after falling. (Resident #H and #J) Findings include: 1. On 8/15/11 at 3:25 p.m., Resident #H was observed lying in bed. While walking up to the resident's bed and sitting in the arm chair next to the bed, there was no evidence a sensor alarm was sounding or turned on by the resident's bed. On 8/16/11 at 2:22 p.m., the resident was out of her room. While walking around her room and around the resident's bed, there was no evidence a sensor alarm was not turned on and functioning. On 8/17/11 at 4:12 p.m., the resident was observed sitting on the side of	F0323	1. Immediate action was taken On the date of this finding regarding resident H. An interdisciplinary meeting and meeting with resident H held to address alarms and safety. The sensor alarm for Resident H was discontinued. Other interventions were updated and added to the care plan. Immediate action was taken for Resident J who was given dycem and the chair alarm turned on at the time of this finding. 2. Other residents were identified by a review of the clinical records for preventative devices for falls. All devices for falls were confirmed to be on and working.3. The system in place will be reviewed during Inservice training with direct care staff. The inservice training will include proper use of devices. Nursing staff will apply devices as indicated by the charge nurse and care plan. 4. The system will be monitored by the Unit Manager / designee who will do an audit three times per week for three months, then quarterly thereafter, to ensure fall devices are in place and working. The results of the audit will be forwarded to the QA Committee for their review and any concerns will be addressed. AddendumThe system will be monitored by the unit	09/22/2011

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	her bed, while approaching her and standing approximately one foot from her bed, the sensor alarm did not sound. Further observation at that time, indicated the PCU Unit Manager entered the room and turned a switch on the sensor alarm that was located on the wall parallel to the resident's bed. The alarm immediately sounded. CNA #1 was observed to come into the room, she indicated that she did not know what the device was on the wall, and she had no idea what a sensor alarm was. Interview with LPN #1 on 8/17/11 at 4:22 p.m., indicated she had no idea Resident #H used a sensor alarm. Interview with LPN #2 on 8/17/11 at 4:24 p.m., indicated she was the nurse taking care of the Resident #H and she had no idea the resident had a sensor alarm in place. The record for Resident #H was reviewed on 8/17/11 at 8:23 a.m. The resident's diagnoses included, but were not limited to, gait difficulty secondary to lumbar compression, anxiety, fracture of right humerus, and sprained right knee. Review of the initial Minimum Data Set (MDS) assessment dated 5/3/11,		manager/designee who will do an audit three times per week in which the audits will be rotated to cover all three shifts.	

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	indicated the resident was alert and oriented with limited assist with transfers, bed mobility, toileting, and locomotion on unit. The resident had a history of falls prior to admission and a fracture related to a fall in last six months prior admission. Review of the Fall Risk Assessment dated 4/26/11, indicated the resident was a low risk for falls. Review of the Fall Risk Assessment dated 7/22/11, indicated she was a high risk for falls with three or more falls in last 3 months. Review of the personal alarm assessment 4/26/11, indicated the resident had previous falls, the resident does try to stand, transfer, and walk alone, and staff have to remind her to use the call light. Review of the personal alarm assessment dated 7/22/11, indicated the resident has had previous falls, tries to get out bed unsafely, tries to stand, transfer and walk alone. The resident cannot walk to and from the bathroom due to her balance and unsafe gait. The resident does have poor safety awareness and decision making, and requires assistance with toileting and ambulation and often refuses to use the call light for assistance.			

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The current care plan dated 6/7/11, indicated the resident had the potential for falls related to history of falls and an unfamiliar environment. The nursing approaches were for a sensor alarm and a bed and chair alarms.

Review of the Nursing Progress Notes dated 5/4/11, at 8 p.m., indicated the resident was found on floor in her room and both bed and chair alarms were in place but not sounding. The resident indicated she had turned them off.

Review of the Fall Investigation Worksheet dated 5/4/11, indicated the resident's bed and wheelchair alarms were not sounding and the resident stated, "I turned them off. They irritate me." The interventions put into place at the time of the fall was to provide the resident non-skid safety socks to wear, therapy to evaluate her, and continue with bed and chair alarms.

Review of Nursing Progress Notes dated 5/14/11 12:15 p.m., indicated the resident transferred herself from a chair to the wheelchair. The resident was observed sitting on the floor in front of her chair. The resident

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	indicated she slid out of the chair. Review of the Fall Investigation Worksheet dated 5/14/11, indicated the resident's alarm was sounding at the time of the fall. The new interventions at the time of the fall was to place a dycem in the wheelchair. Review of Nursing Progress Notes dated 6/7/11, at 3:30 a.m., indicated nursing staff heard a loud noise and upon entering the room the resident was on the floor. The resident indicated she took the bed alarm apart, got out of bed and ambulated to get a brief out of her closet. The resident had complaints of pain to her right arm at that time. Nursing Progress Notes dated 6/7/11 at 7:30 a.m., indicated the resident refused to get out of bed due to pain in her right arm. The resident's physician was called and new orders were obtained to send the resident to the hospital to get an X-ray. Review of the X-ray results dated 6/7/11, of the right shoulder, indicated the resident had a comminuted fracture of the head of the humerus and the surgical neck with slight impaction.			

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TIMBERVIEW HEALTH CARE CENTER	2350 TAFT STREET GARY, IN46404

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	Review of the IDT notes dated 6/7/11, indicated reviewed resident's history of falls. Resident noncompliant with use of alarm to bed. Resident with a history of disconnecting or dismantling alarms. Sensor alarm to be placed in resident room. Care plan updated. Review of Nursing Progress Notes dated 7/7/11 at 6:00 p.m., indicated the resident was found on the floor in room. The resident was observed in front of wheelchair sitting on her buttocks. Review of the Fall Investigation Worksheet dated 7/7/11, indicated the alarms were not sounding. Review of Nursing Progress Notes dated 7/30/11 7:20 p.m., indicated the resident noted to be sitting on the floor in her bathroom. The resident stated she was walking from the toilet to the sink to wash up and put on night clothes. The alarm was sounding. Review of Physician orders dated 4/29/11 and on the current 8/11 recap indicated check bed alarm for placement and functioning every shift and check chair alarm for placement and functioning every shift.			

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Interview with the PCU Unit Manager on 8/18/11, at 4:55 p.m., indicated she had not tried any other type alarms or hiding the resident's alarms under the wheelchair or the bed due to her noncompliance. She further indicated the sensor alarm was to be turned on and in place at all times.

Interview with the Director of Nursing on 8/19/11 at 11:13 a.m. indicated there was no documentation in the fall investigations report that the resident was wearing her non skid socks at the time of the fall on 6/7/11. She further indicated the bed and chair alarms continued to be an intervention for the resident, even though she was noncompliant with all of the alarms.

2. On 8/17/11, at 4:00 p.m., Resident #J was observed up in a wheelchair. There was a chair alarm noted to the chair, and there was a chair cushion on the bottom of the chair.

On 8/17/11 at 4:13 p.m., CNA #1 was observed in the resident's room, at that time, she indicated she placed the resident in the wheelchair that she was currently sitting in. The CNA indicated she had thought this was Resident #J's wheelchair. Further

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	observation at the time, indicated the CNA was asked to stand Resident #J up from the chair. The PCU Unit Manager and CNA #1 then stood the resident up from the wheelchair. The chair alarm did not sound. Further observation indicated the chair alarm was turned off. There was also no dycem noted on top of the cushion or under the cushion in the wheelchair. The record for Resident #J was reviewed 8/17/11 at 3:30 p.m. The resident's diagnoses included, but were not limited to, multiple sclerosis and Parkinson disease. Review of quarterly MDS assessment dated 6/16/11, indicated the resident was alert and oriented and needed extensive assistance with bed mobility, transfers, locomotion on unit, dressing, eating, toilet use, and personal hygiene. The resident had no falls prior to the last assessment. The current plan of care dated 6/17/11, indicated the resident was at risk for falls. The nursing approaches were to have bed and wheelchair alarm and a dycem to the wheelchair. Review of Physician orders dated 1/20/11, and on current 8/11 recap,			

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	indicated bed and wheelchair alarm check function and placement every shift. Review of Nursing Notes dated 7/27/11, indicated the resident had a fall at 3:30 p.m. The resident was noted on the floor in her room lying on her left side. The resident indicated she was trying to pick up her call light that had fallen to the floor. Interview with the PCU Unit Manager on 8/17/11 at 4:30 p.m., indicated the resident was to have wheelchair alarm and a dycem under her cushion while up in the wheelchair. 3.1-45(a)(2)			

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F0334 SS=D	The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes			

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	documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.			
	Based on record review and interview, the facility failed to ensure each resident received the pneumococcal immunization for 1 of 5 residents reviewed for pneumococcal immunizations. (Resident #J) Findings include: The record for Resident #J was reviewed on 8/17/11 at 1:20 p.m. The resident was admitted to the facility on 10/22/10. The Quarterly MDS (Minimum Data Set) assessment, completed on 6/1/11, indicated the pneumococcal vaccine was not offered to the resident. The resident's immunization record	F0334	1. Immediate action was taken whereby the family of resident J was notified and pneumococcal immunization administered after survey.2. Other residents were identified through an audit which was completed on all residents who consented for the pneumococcal immunization and those identified as not having the immunization have been scheduled. 3. The systemic change will consist of a generated report which will be utilized by each unit manager/designee to monitor compliance to ensure that residents with consents to receive the pneumococcal vaccine are given. 4. The corrective action will be monitored by the Unit Manager/designee using the generated report to audit all new	09/22/2011

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	was reviewed. There was no documentation the resident had received the pneumococcal vaccination. A form titled "Informed Consent for Vaccinations" was reviewed. The consent form was signed by the resident's responsible party and was dated 12/25/10. The family member gave her consent for the resident to receive the pneumococcal vaccine. Interview with the Director of Medical Records on 8/19/11 at 8:39 p.m., indicated the resident had not received the pneumococcal vaccine since her admission to the facility on 10/22/10. The undated policy titled, "Policy for Pneumococcal Vaccination of Residents" was provided by the DON on 8/17/11 at 10:30 a.m. She indicated the policy was current. The policy indicated, "It is the policy of this facility that each resident or their responsible party will be asked on admission if they have previously had the pneumococcal vaccination and their age at the time of vaccination. The records that accompany the resident also will be used to determine immunization status. If there is not prior evidence of		admissions weekly. Results will be shared in monthly QA meetings for three months and quarterly thereafter.	

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	vaccination, the vaccine will be offered to the resident at that time." Interview with the PCU Manager on 8/22/11 at 8:30 a.m., indicated she was not aware each resident was to be offered a pneumococcal vaccine. She indicated she did not know if the resident had received the pneumococcal vaccine prior to admission to the facility and if she was eligible to receive the vaccine. On 8/22/11 at 8:50 a.m., interview with the PCU Manager, indicated she had spoken to the resident's responsible party, and the daughter indicated the resident had not received the pneumococcal vaccine in the past and was eligible to receive the vaccine. 3.1-13(a)			

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F0368 SS=B	Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served. Based on record review and interview, the facility failed to ensure there was no more than 14 hours between the evening meal and the breakfast meal. This had the potential to affect 116 of the 125 residents who resided in the facility. Findings include: Review of the meal times provided by the facility on 8/22/11 at 2:00 p.m., indicated the Main Dining Room served dinner at 5:15 p.m. and breakfast was served at 8:30 a.m. The time between dinner and breakfast was over 15 hours. Review of the Resident Council minutes on 8/19/11 at 9:00 a.m.,	F0368	1. Residents suffered no ill effects as a result of the scheduled meal times in the Main Dining Room. Snacks were being provided at the time of this finding.2. No residents were identifed at the time of survey. 3. The systemic change will be that the Dining times will be be reviewed on a semi-annual basis to ensure correct times have not been changed. 4. The systemic change will be reviewed by the Administrator or Designee who will review the posted dining times semi-annually to ensure the posting is correct. Any concerns shall be discussed in the quality assurance meetings on a quarterly basis. AddendumThe current meal times in the facility are 7:30, Noon, and 5:30.	09/22/2011

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	indicated there was no documentation related to the meal times in the past three months. Interview with the Administrator on 8/22/11 at 2:24 p.m., indicated that she did not have any documentation to indicate if the meal times were discussed in the resident council meeting. 3.1-21(f)			
F0406 SS=D	If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services. Based on observation, record review, and interview, the facility failed to ensure specialized rehabilitation services for Occupational therapy were initiated in a timely manner for 1 of 3 residents reviewed for range of motion of the 9 who met the criteria for range of motion. (Resident #G) Findings include:	F0406	1. Immediate action was taken for Resident G who was evaluated by therapy staff. 2. To identify other residents, for all residents to ensure that no outstanding therapy orders are in place.3. The system will be reviewed with the rehabilitation team who will be inserviced to ensure timely evaluation of residents with orders.4. The corrective action will be monitored by the Rehabilitation Manager or	09/22/2011

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	On 8/16/11 at 2:20 p.m., Resident #G was observed sitting in an electric wheelchair in her room. The resident's left fingers were closed in a fist and the resident was not able to open the hand upon command. The record for Resident #G was reviewed on 8/16/11 at 2:25 p.m. The resident was admitted to the facility on 8/4/11. The residents diagnoses included, but were not limited to, cerebral vascular accident (stroke), hemiplegia, and asthma. The 8/4/11 Nursing Admission Assessment indicated the resident had a contracture to the left arm. Review of the 8/4/11 admission Physician orders indicated an order was written for Physical and Occupational Therapy to evaluate the resident for services. The first Occupational Therapy plan of care was initiated on 8/10/11. The plan of care indicated the resident was evaluated on this date and therapy services started on 8/10/11. The plan of care indicated the resident was referred to Occupational Therapy as the resident had no active range of motion of the left hand and had a contracture to the left hand.		designee who will be responsible for auditing each admission for timely evaluation of residents with therapy orders for one month. Following the first month, five records per month will be completed for compliance with timely evaluation of therapy services. The results will be shared monthly in Quality Assurance meeting.	

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	When interviewed on 8/17/11 at 1:57 p.m., the interim Rehabilitation Manager indicated therapy staff should have evaluated the resident the day she was admitted and the orders were written or the day after. 3.1-23(a)			
F0412 SS=D	The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. Based on observation, record review and interview, the facility failed to provide routine dental visits for 1 of 3 residents reviewed for dental of the 4 who met the criteria for dental. (Resident #H) Findings include: On 08/15/2011 at 3:32 p.m. Resident #H was observed sitting on the side of her bed. At that time, her front left tooth was observed to be yellow and decayed with pieces of her tooth broken off. The resident was also missing other teeth in her mouth.	F0412	1. Immediate action was taken for Resident H who received dental consultation. 2. Other residents were identified by a review of resident records to ensure compliance with this requirement. 3. The system in place is one in which Social Services will follow up with nursing when a resident receives a dental referral to make sure appointments are set up in a timely manner. Social Service will review referral list after dental visit and follow up with nursing to ensure appointment is made. 4. The system will be monitored by the administrator / designee who will audit three charts a week	09/22/2011

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	Interview with the resident at that time indicated about five years ago while taking some sort of medication it had caused all of her teeth to decay. The resident stated "All of my teeth are starting to rot." The resident indicated that she wanted dentures. The record for Resident #H was reviewed on 8/17/11 at 8:23 a.m. Review of the Initial Nurse Assessment dated 4/26/11, indicated the resident had her own teeth with broken and carious teeth noted. Interview with the Social Service Director on 8/18/11 at 1:34 p.m., indicated the resident was not on the list to be seen by the dentist. The Social Service Director indicated the dentist visits the facility once a month and was scheduled to be here the week of 8/29/11. She further indicated it was nursing's responsibility to make sure she knew when residents were in need to see the dentist and they had not made any special requests for the resident to see the dentist. Interview with the PCU Unit Manager on 8/18/11 at 3:55 p.m. indicated she was not aware the resident wanted to see the dentist or had bad teeth.		for one month to ensure compliance with this requirement. Following the first month, audits will be conducted on a quarterly basis by the Administrator/designee until 100% compliance with this requirement. Results will be shared with the quality assurance committee on a monthly basis for three months.	

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F0431 SS=D	3.1-24(b) The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, record review and interview, the facility failed to ensure a label change was completed following a medication dose change for 1 of 10 residents reviewed for	F0431	1. Immediate action was taken for Resident F. The label for medication was changed according to facility policy during survey. Immediate action was taken for Resident #54. The	09/22/2011

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	unnecessary medications in the Stage 2 Sample of 38. The facility also failed to ensure insulin vials were dated when opened for 2 of 12 residents receiving insulin on the PCU Unit. (Residents #F, #54, and #70) Findings include: 1. On 8/18/11 at 1:33 p.m., LPN #2 was observed preparing medications for Resident #F. The LPN proceeded to place 4 milliliters (ml's) of Dilantin (a medication used to treat seizures) in a medication cup. The label on the bottle indicated the resident was to receive 125 milligrams (mg) per 5 ml's. The LPN indicated the resident's dilantin order had been changed. There was no sticker on the bottle of dilantin to indicate an order change. The record for Resident #F was reviewed on 8/16/11 at 2:38 p.m. The resident's diagnoses included, but was not limited to, seizures. A physician's order dated 8/10/11, indicated the resident's Dilantin was to be changed to four ml's three times a day starting on 8/12/11. Interview with the North Unit Manager on 8/18/11 on 4:21 p.m., indicated the order on the label of Dilantin did not		medication was replaced with an unopened vial during survey. Immediate action was taken for Resident #70. The medication was replaced with an unopened vial during survey. 2. To identify other residents, each resident's medications were checked for date opened labels, and for changing direction of medication. No further concerns noted after audit check.3. The system in place will be reviewed through inservice training regarding our policy and procedures for package and labeling of medication. 4. The system will be monitored by the Unit manager/charge nurse who will check medication cart, refridgerator for unlabeled medication, and change in dosage of medication. Audit will be conducted three times per week for one month and quarterly thereafter. compliance has been met. Results will be reviewed in monthly quarterly assurance meetings.	

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	match the current order. She further indicated she was not aware if they should put an order change label on the bottle and she would have to check the pharmacy policy. 2. The medication storage room on the PCU unit was observed on 8/18/11 at 3:30 p.m. There was a vial of Novolin R (Regular) insulin stored in the refrigerator. The insulin vial was labeled with Resident #54's name. The insulin vial was opened. There was no label on the insulin vial to indicate the date the vial was first opened. The record for Resident # 54 was reviewed on 8/22/11 at 7:46 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus and high blood pressure. The 8/11 Physician Order Statement indicated there was a Physician's order for the resident to receive Novolin R insulin per sliding scale coverage four times a day. The 8/11 Diabetic Care Flow Record indicated the resident received doses of Novolin R daily 8/15/11 through 8/19/11. When interviewed on 8/18/11 at 3:30 p.m., the PCU Unit Manager indicated the date the insulin vials were first			

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	opened should have been on the vial. 3. The medication storage room on the PCU unit was observed on 8/18/11 at 3:30 p.m. There was a vial of Lantus insulin stored in the refrigerator. The insulin vial was labeled with Resident #70's name. The insulin vial was opened. There was no label on the insulin vial to indicate the date the vial was first opened. The record for Resident #70 was reviewed on 8/22/11 at 7:54 a.m. The resident's diagnoses included, but were not limited to, diabetes and high blood pressure. There was a Physician's order written on 8/13/11 for the resident to receive Lantus insulin 20 units every evening. The 8/11 Diabetic Care Flow Sheet indicated the resident received the Lantus insulin daily 8/13/11 through 8/21/11. The facility policy titled "Packaging and Labeling" was received from the North Unit Manager on 8/18/11 at 4:35 p.m. The Unit Manager indicated the policy was current. The policy was last revised on 11/3/06. The policy indicated labeling on prescription drugs was to include the date opened and precautionary			

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	labels. The policy also indicated small multidose vials such as insulin vials were dispensed in amber packaging and were to have date opened labels. The policy also indicated "Directions Changed Refer to Chart" stickers were to be placed on medication container labels to indicate a change in the order affecting the administration of the medication. When interviewed on 8/18/11 at 3:30 p.m., the PCU Unit Manager indicated the date the insulin vials were first opened should have been on the vial. 3.1-25(j)			
F0463 SS=D	The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. Based on observation and interview, the facility failed to ensure call systems were functioning for 3 of 40 resident's call lights checked for functioning in the Stage I sample of 40. (Residents #107, #H, and #J) Findings include: 1. On 8/16/11 at 8:52 a.m., the call	F0463	1. Immediate action was taken to repair the call lights for residents#107, J and H on the date of this finding. Maintenance personnel had conducted a random audit of call lights the day before this finding but the rooms for residents #107, J and H were not part of the audit on that date. 2. Other call lights having potential not to be working were identified by an immediate check of all call lights in the facilty to ensure they were functioning	09/22/2011

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	light in Resident #107's bathroom was checked for functioning. The call light cord was pulled and the indicator light did not light up or sound outside of the resident's room or at the Nurses Station. When interviewed at the above time, the PCU Nursing Unit Manager indicated the call light did not light up or sound outside of the room or at the Nursing Station. When interviewed on 8/22/11 at 3:57 p.m., the PCU Nursing Unit Manager indicated Resident #107 was capable of using her call light. 2. On 8/16/11 at 9:01 a.m., the call light in Resident #H and Resident #J's and shared bathroom was checked for functioning. The call light cord was pulled and the indicator light did not light up or sound outside of the resident's room or at the Nursing Station. When interviewed at the above time, the Maintenance Director indicated the call lights did not light up or sound outside of the room or at the Nursing Station at this time. When interviewed at the above time, the PCU Nursing Unit Manager		properly. All were found to be functioning properly. 3. The system in place will be reviewed by staff inservices to be conducted regarding the importance of communicating with maintenance staff or Administrator immediately if they should notice a call light is not working properly. Maintenance staff will audit 20 rooms per week on a rotating schedule to ensure ongoing compliance with this requirement. 4. The corrective action will be monitored by the Administrator or designee who will review call system audits weekly to ensure completion. The audits will be shared in monthly quality assurance meetings until 100% compliance is achieved, then the audits will be presented on a quarterly basis at QA meetings.	

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	indicated the call light indicator did not light up or sound outside of the room or at the Nursing Station. When interviewed on 8/22/11 at 3:57 p.m., the PCU Nursing Unit Manager indicated Residents #H and #J were capable of using their call lights. 3.1-19(u)(2)			
F0465 SS=C	The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure 2 of 2 kitchen areas were functional and sanitary related to paint chipped and marred walls and an accumulation of lime build up on the steam table liners. The facility also failed to ensure there was no accumulation of dust and grease in the nourishment refrigerator and the stove top in 2 of 3 pantry areas. (The main kitchen, PCU pantry, South pantry and PCU pantry) This had the potential to effect 116 of the 125 residents who resided in the facility. Findings include: 1. During the Kitchen Sanitation Tour on 8/19/11 at 2:00 p.m., with the Dietary Food Manager, the following	F0465	1. The corrective action included the kitchen walls which were painted, the steam table and nourishment refrigerator were cleaned immediately. The shelves and interior of refrigerator door were cleaned immediately. The stove, oven, and oven hood were cleaned immediately. 2. Other areas were identified by an audit of all kitchen and nursing unit areas/pantries. Identified concerns were addressed immediately. 3. The system in place is to update current cleaning monitoring tools for kitchen, housekeeping, and activity kitchen area. 4. The Dietary Manager, Housekeeping Supervisor and Activity Director will be responsible for ongoing monitoring of respective areas weekly. Housekeeping, Dietary and Activity Directors / Designee will monitor areas weekly and every two weeks thereafter.	09/22/2011

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	was observed: a. The base of the wall next to the stove and the base of the wall next to the 3 compartment sink and the dish rack in the main kitchen were paint chipped and marred. b. The four steam table liners were discolored and had an accumulation of a white substance around the edges in the PCU pantry. The wall in front of the steam table was marred and had an accumulation of dried food spillage. Interview with the Dietary Food Manager at the time, indicated the above areas were in need of repair and cleaning. 2. The pantry area on the South unit was observed on 8/191/11 at 2:35 p.m. There was an accumulation of spillage on the shelves and inside of the door of the refrigerator. A total of 49 residents resided on the South Unit. When interviewed at the above time, the South Unit Manager indicated the refrigerator was in need of cleaning. 3. The pantry area in the PCU dining/activity room was observed on			

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	8/19/11 at 3:15 p.m. There was an accumulation of food crumbs under the burner covers on the stove. There was an accumulation of grease on the stove knobs and the outside of the oven door. There was an accumulation of dust on top of the oven hood. There was an accumulation of food spillage on the inside of the oven hood. A total of 46 residents resided on the PCU Unit. When interviewed at the above time, the PCU Unit Manager indicated the above areas were in need of cleaning. 3.1-19(f)			
F0505 SS=D	The facility must promptly notify the attending physician of the findings. Based on record review and interview, the facility failed to promptly notify the resident's physician of laboratory results related to a dilantin level and an urine culture for 2 of 10 residents reviewed for unnecessary medications. (Residents #B and #H) Findings include: 1. The closed record for Resident #B was reviewed on 8/18/11 at 8:35 a.m. The resident's diagnoses included, but were not limited to, seizures.	F0505	1. Immediate action could not be taken for resident B as this resident had been discharged from the facility. Immediate action was taken for resident H who was not exhibiting any signs and symptoms of infection. Unable to correct timely response due to event happended in the past. 2. An audit of all residents who receive labs, for the past 30 days was conducted to identify and ensure labs were obtained. Those identified in error families and doctors were notified of abnormal findings. 3. The system in place will be reviewed	09/22/2011

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	Review of Physician orders dated 2/25/11, indicated a dilantin level was to be drawn every week. Review of the laboratory results dated 3/17/11, indicated the phenytoin level (dilantin) was 5.9 (normal was 10-20) a low level. Review of Nurses Notes indicated there was no entries on 3/17 or 3/18/11. There was no documentation the physician was notified of the low dilantin levels. Nursing Progress Notes dated 3/19/11 at 10:39 p.m., indicated the resident had a seizure and was admitted to the hospital. Interview with the South Unit Manager on 8/18/11 at 2:25 p.m., indicated there was no documentation in the resident's record the physician was notified of the low dilantin level. 2. The record for Resident #H was reviewed on 8/17/11 at 8:23 a.m. Review of Physician orders dated 7/27/11, indicated an urinalysis with a culture and sensitivity were ordered. The urine was collected on 7/29/11 and sent to the laboratory. Review of the urine lab results		via inservice training for all licensed nurses on MD notification of labs will be completed no later than September 22, 2011. 4. Compliance will be monitored by an audit tool which has been developed for use by the unit managers /Designee to audit at least five residents two times a week for completion of labs for one month then quarterly until 100% compliance has been met. Results of audit will be persented in monthly QA meetings.	

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	indicated a culture and sensitivity was performed with the final report faxed to the facility on 8/1/11. The culture indicated the resident had an urinary tract infection with greater than 100,000 Escherichia Coli. At the bottom of the lab results, the nurse indicated the results were faxed to the physician on 8/1/11. Review of Physician orders dated 8/3/11, indicated an antibiotic for the urinary tract infection was not ordered until 8/3/11. Review of current 9/05 Physician Notification for Change in Condition policy provided by Nurse Consultant #1, indicated Immediate Notification Problems: These require direct communication with the physician and may not be faxed. Positive urine culture over 100,000 of a pathogen. Interview with the PCU Unit Manager on 8/18/11, at 9:44 a.m., indicated the resident's physician insists that all of his lab results be faxed regardless of the results. She indicated she was unaware of the facility's policy about all infections greater than 100,000 must be called to the doctor and not faxed. 3.1-49(f)(2)			

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F0514 SS=D	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on record review and interview, the facility failed to ensure the resident's medical record was accurate related to the transcription of a dietary supplement for 1 of 3 residents reviewed for nutrition of the 7 who met the criteria for nutrition. (Resident #B) Findings include: The closed record for Resident #B was reviewed on 8/18/11 at 8:35 a.m. The resident's diagnoses included multiple sclerosis. The dietary progress note dated 6/22/11 indicated the resident had a significant weight loss of 15% in the last 90 days. The resident has had gradual weight fluctuations. The resident was fed by staff. The Dietitian had recommended	F0514	1. Immediate action was not applicable for Resident B as this resident had been discharged from the facility. 2. Current resident's charts will be reviewed for any transcription errors. The physician and family will be contacted regarding any discrepencies noted. 3. The system in place will be reviewed via In-service training on transcribing orders for all licensed nursing staff which will be completed no later than September 22, 2011.4. Systemic changes will be monitored by Medical Records/Designee whom will audit at least five charts per week times four weeks then quarterly thereafter. Results will be presented in monthly Quality Assurance meetings.	09/22/2011

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	healthshakes with breakfast and dinner which would provide an extra 200 calories and six grams of protein per shake to increase caloric intake and avoid unintentional weight loss. Review of Physician orders dated 6/23/11 indicated healthshakes twice a day at breakfast and dinner. Review of the Medication Administration Record (MAR) dated 6/11 indicated the healthshakes were transcribed onto MAR as "healthshakes BID (twice daily) at breakfast and lunch" with the times of 1200 (12:00 p.m.) and 1700 (5:00 p.m.). Further review of the MAR indicated the healthshakes were signed out as being given at those times from 6/23-6/30/11. Review of the MAR for 7/11 indicated the healthshake order was not transcribed onto the medication sheet. There was no documentation of healthshakes being given to the resident or the consumption of the healthshake from 7/1-7/18/11. Interview with the South Unit Manager on 8/18/11 at 2:25 p.m. indicated the healthshakes were not transcribed onto the 7/11 MAR as ordered by the doctor. She further indicated the			

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	times for the healthshakes were transcribed for lunch and dinner on the 6/11 MAR. She also indicated at that time the nurses were to monitor the consumption of the healthshakes. 3.1-50(a)(2)			